METHODS: Patient relevant endpoints of treatment (remission of depression, response to treatment, no relapse, serious adverse events, adverse events, social function, anxiety, pain, cognitive function) were prioritized using pairwise comparisons of these outcomes. In two separate groups, twelve patients and seven experts judged on a 9 point scale the relative importance of pairs of two outcome measures. The geometric mean of these judgments was used to derive weighting factors for the outcome measures (scale 0–1). **RESULTS:** Of all outcome measures, patients rated response to treatment highest (0.32), while experts rated remission of depression highest (0.48). Adverse events were all rated lowest by patients as well as by experts, and disease-specific quality of life domains such as social function (0.11 & 0.09), anxiety (0.12 & 0.05) and cognitive function (0.13 & 0.06) were rated in between. **CONCLUSIONS:** The most important outcome measures according to the patients are, in order of decreasing importance: response, cognitive function, no anxiety, social function, no relapse, no adverse events, and remission. The AHP appears to be suitable in gaining an overview of the importance of patient relevant outcome measures. An additional advantage of AHP is that the group discussions offer insight in the question *why* the endpoints are important.

PMH55

THE SUBJECTIVE WELL-BEING UNDER NEUROLEPTIC SCALE SHORT FORM (SWN-K20) AND THE SF-36 AS QUALITY OF LIFE MEASURES IN SCHIZOPHRENIC PATIENTS

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OBJECTIVES: Outcomes research in patients with schizophrenia should take into account the subjective interpretation of the mood and physical changes accompanying medication. Those changes influence the behavioural response to treatment and ultimately the patient's clinical outcome as mediated by his treatment compliance. Our aim was to assess the relationship between a specific well-being measure, the SWN-K20 that presents a general and 5 specific measurement subdomains (mental functioning, social integration, emotional regulation, physical functioning, and self-control), and the 8 domains of the SF-36 v1 as a general quality of life measure. **METHODS:** The validation sample for this study comprised 97 patients diagnosed with schizophrenia and who were rated as clinically stable at the moment of the study (1 week test-retest intraclass correlation coefficient for clinical symptoms = 0.96). The patients were recruited as part of a multicenter psychometric trial to validate the SWN-K20 in Spanish. The associations between the domains of the SWN-K20 and the SF-36 were evaluated by the Spearman's rank correlation test. **RESULTS:** All correlations among domains were positive and most were statistically significant ($p < 0.05$). As expected the bodily pain domain of the SF-36 presented the lower correlations with the SWN-K20 (rho range of 0.10 to 0.25), whereas the other 7 domains correlated significantly with the total SWN-K20 score (rho range 0.49 to 0.60, all $p < 0.001$). Overall the largest correlations were obtained between the SWN-K20 and the SF-36 domains of general health (rho = 0.53), mental health (rho = 0.60), and vitality (rho = 0.54). **CONCLUSIONS:** The positive but nevertheless moderate correlations observed between a specific well-being scale, as the SWN-K20, and a general quality of life scale, as the SF-36, supports the inclusion of specific and diagnose-tailored instruments for outcome assessments of patients with schizophrenia.

PMH56

INNOVATIONS IN COMBINING PATIENT REPORTED OUTCOMES WITH COGNITIVE TESTING DATA TO STREAMLINE AND LEVERAGE REAL-TIME DATA COLLECTION

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OBJECTIVES: Understand features of an electronic device that allow a marked improvement in the quality of collected data; the importance of improved data quality leading to enhanced patient safety and drug labeling; populations best suited for paired PRO and cognitive measurement technologies; important practical considerations for implementation in clinical trials including training and compliance; the potential for using real-time parallel data for adverse event safety monitoring. **METHODS:** This session discusses using ePRO and biometric technology for parallel data capture emphasizing advantages, disadvantages, execution, and ways to leverage these data. The session will review PRO and cognitive testing technologies, including comparisons of devices that combine physiological measures with a patient interface with systems that use separate PRO input and biometric devices. **RESULTS:** Assessing a treatment's ability to enhance or prohibit reduction of cognitive processing efficiency is an emerging study in the pharmaceutical industry. Case studies examine how the use of cognitive function tests in combination with ePRO can enhance the data collection so drug effects otherwise unidentified can be determined. The speaker will discuss the future of ePRO combined with biometric measurements as a standard of clinical research. **CONCLUSIONS:** Clinical trial endpoints can involve collection of physiologic and patient-reported outcome data; a combination of subjective and objective data. Electronic forms of information capture assure trial efficiencies including edit checks and shorter time to database lock. ePRO provides time-stamped, legible and complete data from subjects. Biometric devices capture the physiological measurements. Typically, cognition data have been collected from patients separately from PRO data during clinical trials, increasing respondent burden and risk of error such as transposing manually entering data. The use of ePRO and biometric devices, evolution of data transmission technology, and greater technologic sophistication of consumers, provide an opportunity for parallel electronic data capture, simultaneously capturing and transmitting physiologic and PRO parameters in clinical studies.

PMH57

REVIEW OF CO-MORBIDITY OF EATING AND BODY DYSMORPHIC DISORDERS

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OBJECTIVES: Our intention was to investigate the prevalence of Eating Disorder and Body Dysmorphic Disorder in patients diaghnosed with depression, anxietay and borderline personality disorder by gender, using controll groups. **METHODS:** The reserach was 2009 at the Department of Phsyciatry of Szigetvár Hospital (Hungary). Eating Disorder Inventory was used. a self-made questionnaire aimed the body mass, body height and several demographic data. Inclusion criteria: ones between 18 and 50 years age, and according to BNO F32-F34 (depression), F41 (anxiety), F6030 (borderline personality disorder) diagnoses. Control group: participants with age between 18 and 50 years like that, who do not stand under a psychiatric treatment. The statistical analysis consisted of two sample T test, χ^2-probe. **RESULTS:** The target group's number was 82, the control group 85. In the "The feeling of the insufficiency" ($P < 0.001$), "Interpersonal distrust" ($P < 0.005$), "Interoceptive consciousness" ($P < 0.001$) scales, the members of the control group from all three psychiatric patient groups reached a significantly lower score away. In the "Bulimia" scale there was a significantly lower score in the control group as well than the borderline in a group ($P < 0.005$), and here I found a significant difference between the members of two psychiatric groups: the anxious group reached a lower score, compared with the borderline group ($P < 0.001$). **CONCLUSIONS:** The three psychiatric patient groups did not attain the threshold value onto one of the eating disturbances relevant scales neither There is not a direct, causal contact between the examined psychiatric clinical pictures. The men's higher result achieved on the „Bulimia" scale relates rather onto the binge eating disorder.

PMH58

MODELING PROGRESSION IN DEMENTIA: ASSESSING THE PERFORMANCE OF FIVE CLINICAL MEASURES IN SPANISH SUBJECTS AND CAREGIVERS

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OBJECTIVES: The primary objective of this analysis was to compare five different clinical measures and their impact on economic modelling. Clinical measures compared are the Mini-Mental State Examination (MMSE), the Cognitive Component Score (CCS), the Functional Component Score (FCS) the Behaviour Component Score (BCS), and the Dependence Scale (DS). **METHODS:** The MMSE, CCS, FCS, BCS and DS were compared in their ability to explain variation in clinical outcomes, economic- and other utilized resources, caregiver burden (Zarit Scale) and caregiver QoL (EQ-5D) using univariate (Pearson correlations) and multivariate (linear regression) analyses. Data on subjects and caregivers was obtained from multiple centres in Spain. **RESULTS:** In total 394 subjects, males and females aged 50 to 93 years old with mild cognitive impairment to severe dementia were included in this study. CCS, FCS, BCS and DS were moderately correlated with MMSE, with Pearson correlations ranging from –0.26 for BCS to –0.56 for CCS. These four clinical measures were also moderately correlated with medical costs, Zarit Scale and EQ-5D while MMSE was not. These measures also performed better in explaining variation in medical costs, Zarit Scale and caregivers' EQ-5D. MMSE performed better explaining variation in the number of concomitant conditions and caregiver time (hours per day). **CONCLUSIONS:** The CCS, FCS, BCS and DS are better predictors in modelling AD progression on a higher number of variables including medical costs, caregivers' burden and caregivers QoL than the MMSE.

PMH59

EVALUATION OF THE EFFECT OF ARIPIPRAZOLE ON QUALITY OF LIFE IN PATIENTS WITH SCHIZOPHRENIA IN A PROSPECTIVE, MULTICENTRE, OPEN-LABEL STUDY

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OBJECTIVES: Aripiprazole has been claimed to have a beneficial effect on cognition with an emphasis on verbal functioning in schizophrenic patients. a prospective, multicenter, open-label study of Aripiprazole was set to evaluate the effect on quality of life, in relation to illness severity and cognitive functioning of a treatment with aripiprazole in schizophrenic patients. **METHODS:** A total of 363 schizophrenic patients from 18 to 65 years, treated with different typical and atypical antipsychotics or had no previous treatment, were switched to aripiprazole after a 2 week washout period. Quality of life was assessed by use of the Quality of Life Enjoyment and Satisfaction Questionnaire (QLESQ) at 3 separate test moments in a 12 weeks period.